NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER
NURSING DEPARTMENT

Standard of Practice: Care of the Patient with Potential for Self-Harm/Suicide

I. PREVENTATIVE Assessment

A. Assess each patient for self-harm/suicide potential:
   1. within the first hour of admission to NIMH/NIAAA, or
   2. within one hour of risk identification on all other CCND units/clinics.

B. Nursing assessment will include (but is not limited to):
   1. history of suicidal intent or previous suicide attempts; define situational context this occurred in.
   2. thoughts of suicide, both active and passive.
   3. current suicidal intent.
   4. existence of specific plan.
   5. availability of means to follow through with plan.
   6. elopement potential.
   7. risk factors (e.g., hopelessness; substance use; impulsivity; burden to others; level of energy; recent mood elevation, especially associated with pharmacologic treatment).
   8. inadequate support system

C. Psychiatric liaison nurse and/or psychiatrist assessments/consultations are utilized as required by patient's **(**and/or treatment team's) needs (MIS Psychiatric Consult; if need is imminent, call page operator and request NIMH OD).

D. Ongoing assessment of suicide potential will be conducted as determined by risk and communicated to treatment team.

II. Intervention

A. Communicate positive findings and risk factors to treatment team, specifically to patient's physician.

B. Consider the following interventions in collaboration with treatment team:
   1. increase in observation status;
   2. restriction to unit or change in privilege status;
   3. unit search, patient room search, patient search;
   4. increase frequency of case management appointments and/or telephone monitoring;
   5. refer and assist patient in accessing psychiatric care and follow-up;
   6. assess patient's ability to contract for safety; establish contract if reliable;
   7. recommendation for pharmacologic treatment of target symptoms

C. Considering risk profile, develop and implement an outcome-based, individualized prevention plan with multidisciplinary input.
D. Evaluate efficacy of interventions to diminish risk of self-harm. Increase frequency of re-evaluation as patient's risk for self-harm potential increases.

III **Documentation**

A. Documentation will include details of assessment (see above, including any consultations); specifics of communication to physician, multidisciplinary team, and referral clinicians; intervention and evaluation**,** and frequency of re-evaluation; ongoing plan for care (e.g., Potential for Self Harm or Physical Injury Potential nursing diagnoses).

IV. **REFERENCES:**

1. Clinical Center Nursing Department Policy: Nursing Responsibility for Identification of Patients with Potential for Self-Harm/Suicide, 5/00.
2. Clinical Center Nursing Department Policy: Observation Levels for Behavioral Health Patients, 5/00.
3. Clinical Center Nursing Department Policy: Privilege Status for Behavioral Health patients, 5/00.
4. McFarlane, G., and Thomas, M., eds. 1991. Spillers, G. Suicide Potential. Psychiatric Mental Health Nursing. Lippincott, chapter 22.
5. Kral, M.J., Sakinofsky, I. 1994. Clinical Model for Suicide Risk Assessment, Death Studies, 18: 37-39 and 311-326.
6. Sederer, LI. 1994. Managing Suicidal Inpatients, Death Studies, 18: 471-482.

Approved:

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